Supreme Court, U.S.
FILED
JAN 28 2015
OFFICE OF THE CLERK
SUPREME COURT, U.S.

No. 14-114

IN THE

Supreme Court of the United States

DAVID KING, ET AL.,
Petitioners,

v.

SYLVIA BURWELL, SECRETARY
OF HEALTH AND HUMAN SERVICES, ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF FOR THE AMERICAN ACADEMY OF PEDIATRICS, AMERICAN ACADEMY OF FAMILY PHYSICIANS, CHILDREN'S HEALTH FUND, CHILDREN'S HOSPITAL ASSOCIATION, FIRST FOCUS, MARCH OF DIMES, NATIONAL PHYSICIANS ALLIANCE, AND INDIVIDUALS WITH PRE-EXISTING MEDICAL CONDITIONS AS AMICI CURIAE IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE*

Amici represent two of the most vulnerable groups in society: children and individuals with life-threatening medical conditions.[1] Amici believe that a ruling in favor of Petitioners would make it difficult, if not impossible, for low- to moderate-income children and individuals with serious medical conditions to obtain health insurance coverage—precisely the results Congress wanted to avoid in enacting the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 ("ACA" or "Act"). Amici therefore believe that the judgment of the Fourth Circuit should be affirmed.[2]

INTRODUCTION AND SUMMARY OF ARGUMENT

This case turns on the meaning of the phrase "Exchange established by the State" in the ACA provision setting forth the method for calculating tax credits for low- to moderate-income individuals purchasing insurance on an Exchange—i.e., a marketplace allowing consumers to compare and purchase individual health plans. *See* 26 U.S.C. § 36B(c)(2)(A)(i); Pet. Br. 3. The same phrase also appears in a key ACA provision relating to the Children's Health Insurance Program ("CHIP"), a primarily federally-funded program that provides in-

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[1] No counsel for any party authored this brief in whole or in part, and no person other than amici, their members, or their counsel made any monetary contribution intended to fund the preparation or submission of this brief. The parties' letters consenting to the filing of this brief have been filed with the Clerk's office.

[2] A full list and description of amici appears in the appendix to this brief.

surance to millions of children from low- to moderate-income families. Recognizing the importance of children's healthcare, Congress sought to guarantee that children would continue to have health insurance in the event of a shortfall in federal funding for CHIP or a nonrenewal of the program. To that end, Congress provided that any eligible children excluded from the program shall be enrolled on a CHIP-equivalent plan "offered through an Exchange established by the State." 42 U.S.C. § 1397ee(d)(3)(B).

According to Petitioners, the phrase "Exchange established by the State" refers exclusively to Exchanges set up by states with no assistance from the federal government ("State Exchanges," for short). Pet. Br. 11. If adopted, that interpretation would have harmful consequences in states with federally-facilitated Exchanges ("Federal Exchange states"). Children on CHIP would lose access to affordable insurance in the event of a CHIP funding shortfall. Individuals with pre-existing, life-threatening medical conditions would lose access to the tax credits that enable them to obtain health insurance, and thus essential, life-saving treatments. And individuals who maintain insurance would face costly premium spikes, leading to an adverse-selection "death spiral."

The ACA was specifically designed to *avoid* such consequences. Construing the Act in a manner that creates them would contravene the express purpose of the law. Congress reformed the healthcare and insurance markets in order to provide access to vulnerable Americans. It did not undo that work by including the phrase "Exchange established by the State" in a handful of statutory provisions. It defies logic to suggest that the Congress that passed the

ACA intended to imperil the functioning of a longstanding children's health program, render millions of the nation's poorest and sickest citizens ineligible for tax credits and thus affordable insurance, and exacerbate the adverse selection and premium shock problems it set out to avoid.

I. Petitioners' position would seriously undermine the functioning of CHIP.

A. CHIP is a bipartisan success story. Enacted as part of the Balanced Budget Act of 1997, and renewed on four different occasions, CHIP has provided health insurance to millions of previously-uninsured children from families that do not qualify for Medicaid and cannot afford private insurance. CHIP coverage, in turn, increases children's access to healthcare and provides their families with peace of mind. Yet despite CHIP's success, the program has been threatened by funding shortfalls and the possibility of nonrenewal.

B. As the ACA was under debate, Congress gave extensive consideration to how to guarantee continued coverage for low-income children. CHIP was scheduled to expire in 2013, and Congress sought to continue CHIP's successes in the ACA while eliminating the risks to children posed by inadequate or nonexistent federal funding. After debating different proposals, Congress ultimately elected to reauthorize the program through 2019 and continue the program's funding through September 2015. Critically, Congress also enacted a backstop in the event federal CHIP funding proved insufficient or was discontinued. In a subparagraph titled "Assurance of exchange coverage for targeted low-income children unable to be provided health assistance as a result of

funding shortfalls," Congress required states to enroll any eligible children left out of CHIP in an equivalent plan on the "Exchange established by the State." 42 U.S.C. § 1397ee(d)(3)(B). In the words of one of the principal sponsors of the CHIP extension, "the goal of this legislation is four words: 'No child worse off.'" 155 Cong. Rec. S11,457 (Nov. 18, 2009) (Sen. Casey).

C. Petitioners' construction of the phrase "Exchange established by the State" would undercut the CHIP backstop provision, and so too Congress's goal of ensuring continuing coverage for children in need. On Petitioners' view, Congress intended to provide backup coverage only for children with access to State Exchanges—even though the program Congress was backing up provides coverage to *all* CHIP-eligible children. Nothing in the program's history or the proceedings surrounding the CHIP reauthorization suggest that Congress had such a counterintuitive result in mind, and no sound policy reason supports it. Petitioners' construction would also have widespread harmful consequences if Congress does not renew CHIP funding later this year—a very real possibility. Up to 5 million children could lose access to affordable insurance coverage based on the happenstance of geography. The Congress that sought to reaffirm and reinforce CHIP would not have undermined it.

II. Petitioners' position would also unwind the core insurance reforms in the ACA.

A. In enacting the ACA, Congress recognized that the individual insurance market was routinely denying coverage or charging increased premiums to individuals with conditions as common as pregnancy

and as serious as cancer. But prohibiting those practices would not alone constitute a workable remedy, because it would trigger adverse selection problems. Accordingly, Congress required individuals to purchase insurance coverage or pay a tax penalty, and provided tax credits for Exchange coverage to ensure that the former option is affordable and thus a meaningful one. The tax credits are an essential part of the ACA's reform.

B. If Petitioners prevail, millions of Americans would lose tax credits, and thus the ability to afford insurance and obtain necessary medical care. The statistical impact would be enormous: 7.1 million Americans, including millions with pre-existing health conditions, purchased insurance on federally-facilitated Exchanges through January 2015, and most received tax credits that reduced premiums by an average of 76%. A substantial majority of those individuals would lose that necessary financial assistance if Petitioners' challenge succeeds. One study predicts that as many as *8 million* people would forgo insurance altogether in Federal Exchange states, rather than pay full premiums. The departure of healthy individuals from the insurance marketplace would drive premiums still higher, resulting in the type of "death spiral" that the ACA was designed to forestall. The fact that Petitioners' reading of the phrase "Exchange established by the State" would undo virtually all of the ACA's reforms provides ample reason to reject it.

III. CHIP and the ACA have allowed countless Americans to survive life-threatening illnesses and serious injuries and enjoy personal and financial liberty and security. Just a few anecdotes of their experiences are enough to confirm that Congress did

not intend to condition the availability of backstop CHIP coverage and insurance tax credits on a state's administrative decisions regarding its Exchange. Depriving Americans of those benefits based on a tortured textual argument makes no practical or legal sense.

ARGUMENT

I. PETITIONERS' CONSTRUCTION OF THE ACA COULD DEPRIVE MILLIONS OF CHILDREN OF INSURANCE COVERAGE AND ACCESS TO AFFORDABLE HEALTHCARE

A. For Almost Two Decades, CHIP Has Provided Children From Low- And Moderate-Income Families With Access To Healthcare

Passed with broad bipartisan support as part of the Balanced Budget Act of 1997, CHIP has provided health insurance to millions of children who otherwise would have been uninsured. *See* Mathematica Policy Research, CHIPRA Mandated Evaluation of the Children's Health Insurance Program: Final Findings at ix (Aug. 1, 2014) (Mathematica Report);[3] The Kaiser Comm'n on Medicaid & the Uninsured, Children's Health Coverage: Medicaid, CHIP and the ACA 2 (Mar. 2014) ("Kaiser Report").[4] Prior to CHIP's enactment, the Medicaid program provided health insurance coverage to all children from families with incomes up to the federal poverty line. Kai-

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[3] Available at http://aspe.hhs.gov/health/reports/2014/CHIPevaluation/rpt_CHIPevaluation.pdf.

[4] Available at http://kff.org/health-reform/issue-brief/childrens-health-coverage-medicaid-chip-and-the-aca/.

ser Report at 2.[5] But there was no comparable coverage for children from families with incomes that were higher than the federal poverty line, but still too low to afford private insurance coverage. For example, a child from a working class family of four in Alabama with an adjusted gross income of $33,000 last year would be ineligible for Medicaid (because the family makes well more than the federal poverty line of $23,550), but her family surely could not afford insurance on the private market. *See* Department of Health & Human Services, Annual Update of the HHS Poverty Guidelines, 78 Fed. Reg. 5182, 5182-83 (Jan. 24, 2013). CHIP fills that gap.

Like many federal programs, CHIP is a federal-state partnership. If states elect to participate in the program, they must comply with minimum coverage requirements established by the Centers for Medicare and Medicaid Services. But CHIP was designed to give states more control over program particulars in the hopes that the programs would "more closely resemble[] options available in the commercial insurance market." Mathematica Report at xi. States that establish a program also receive substantial federal funding to defray program costs—on average, the federal government covers 70% of CHIP expenses, compared to just over 50% for Medicaid. Kaiser Report at 2. This cooperative federalism scheme has worked: Every state and the District of Columbia

[5] Medicaid also extended to all children five and younger from families with incomes up to 133% of the federal poverty line. Kaiser Report at 2.

has participated in CHIP since 2001.[6] Mathematica Report at xi.

By any measure, CHIP has "succeeded in expanding health insurance coverage to the population it is intended to serve, particularly children who would otherwise be uninsured, increasing their access to needed healthcare, and reducing the financial burdens and stress on families associated with meeting children's healthcare needs." *Id.* By the end of Fiscal Year 2013, *8.4 million* children had enrolled in CHIP; just over 5 million of those children reside in Federal Exchange states, and the rest live in states that operate their own Exchanges. Medicaid & CHIP Payment & Access Commission, Report to the Congress on Medicaid & CHIP 68-69 (Mar. 2014) (MACPAC Report).[7] In combination with Medicaid, CHIP has helped reduce the uninsured rate for children to 7%—the lowest number *in history*. Kaiser Report at 3. The programs, in other words, have worked "to provide an insurance safety net for low-income children during economic hard times." Mathematica Report at ix. "Children in Medicaid and CHIP experienced better access to care, fewer unmet needs, and greater financial protection than children who were uninsured." *Id.* at x.[8]

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[6] The only exception is Arizona—discussed in more detail below, *see infra* n.23—which has been phasing out CHIP since the ACA's enactment. *See* Georgetown University Health Policy Institute, Dismantling CHIP in Arizona: How Losing KidsCare Impacts A Child's Health Care Costs 1 (May 2014) (Losing KidsCare) *available at* http://ccf.georgetown.edu/wp-content/uploads/2014/05/Dismantling-CHIP-in-Arizona.pdf.

[7] Available at http://www.macpac.gov/reports.

[8] States can also use CHIP funds to provide insurance coverage to pregnant women. Families USA, CHIPRA 101: Over-

While CHIP's success has been constant, its funding has not. The original iteration of the program was funded for ten years, through 2007. *See* American Academy of Pediatrics, Children's Health Insurance Program (CHIP): Accomplishments, Challenges, and Policy Recommendations at e785 (Jan. 27, 2014) (AAP Report).[9] But the initial formula used to distribute federal funding among states did not accurately predict state needs, leading to significant federal funding shortfalls in many states, and the possibility of enrollment caps or reductions in income eligibility levels. *See* Center on Budget Policy and Priorities, CHIP's Success Not an Argument for Block-Granting Medicaid at 4, 6 (June 28, 2011) (CBPP Study).[10] Congress initially avoided those adverse results by redistributing unspent federal funds from other states. *Id.* at 5. Yet that solution was only a short-term fix. Some states had to cap enrollment anyway because of state budget problems resulting in insufficient *state* funds. *Id.* at 6. And eventually, redistribution of federal funds stopped working too—from 2006 to 2008, nearly 20 states faced significant federal funding shortfalls. *Id.* at 5. Congress was forced to appropriate additional federal funding in separate bills. *Id.* By 2008, in fact, Congress's additional appropriations represented more than 14% of federal CHIP spending. *Id.*

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view of the CHIP Reauthorization Legislation 1 (Mar. 2009), available at http://familiesusa.org/sites/default/files/product_documents/chipra-101-overview.pdf.

[9] Available at http://pediatrics.aappublications.org/content/133/3/e784.full.pdf.

[10] Available at http://www.cbpp.org/files/6-29-11health.pdf.

In addition to these state-specific funding shortfalls, CHIP's overall funding has not always been certain. In 2007, as the original funding was set to expire, both houses of Congress voted to expand CHIP and also extend it for another five years. AAP Report at e785. President Bush twice vetoed that legislation. *See* David Stout, *Bush Vetoes Children's Health Bill*, N.Y. Times, Oct. 3, 2007; Sheryl Gay Stolberg, *President Vetoes Second Measure to Expand Children's Health Program*, N.Y. Times, Dec. 13, 2007. Congress and President Bush instead agreed on stopgap legislation to continue the program for 18 months, through March 2009. AAP Report at e785; *see* Families USA, CHIPRA 101: Overview of the CHIP Reauthorization Legislation 1 (Mar. 2009).[11]

In 2009, with the veto threat lifted, Congress reauthorized CHIP through 2013 and expanded the program to cover 4.1 million new children. Robert Pear, *Obama Signs Children's Health Insurance Bill*, N.Y. Times, F ɔ. 4, 2009; The Kaiser Comm'n on Medicaid & the Uninsured, State Children's Health Insurance Program (CHIP): Reauthorization History 1-2 (Feb. 2009).[12] In addition, Congress provided for a CHIP contingency fund in yet another attempt to address the funding shortfalls that had plagued the program in the preceding years. *See* Medicaid & CHIP Payment & Access Commission, MACBasics:

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[11] Available at http://familiesusa.org/sites/default/files/product_documents/chipra-101-overview.pdf.

[12] Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7743-02.pdf.

Federal CHIP Financing at 2-4 (Sept. 2011)[13]; CBPP Study at 6 (in reauthorizing CHIP in 2009, Congress recognized that state funding shortfalls had caused "losses in children's coverage," and "took various steps to ensure that no states faced *federal* funding shortfalls that could result in enrollment caps or reductions in CHIP eligibility levels").

B. The ACA Not Only Renewed CHIP, But Took Steps To Make The Program More Comprehensive

CHIP's history and future were critical issues in the healthcare reform efforts that culminated in the ACA. The program's funding was set to expire in 2013, placing Congress at a crossroads. Congress knew that CHIP had achieved great success in providing children access to affordable healthcare, and their families with peace of mind. But Congress was also contemplating fundamental structural changes to the healthcare and insurance markets, necessitating reconsideration even of programs that were working as designed.

The bills proposed by the House and Senate contained different models for continuing to provide insurance to low- and moderate-income children. The House's healthcare reform bill would have eliminated CHIP: Children from families with incomes below 150% of the federal poverty line would be transitioned to Medicaid, and all other formerly-CHIP-eligible children would be enrolled on a single, nationwide insurance exchange. *See* The Affordable Health Care for America Act, H.R. 3962, 111th Cong.

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[13] Available at http://www.gpo.gov/fdsys/pkg/GPO-MACPAC-MACBasics-CHIP-2011-09/pdf/GPO-MACPAC-MACBasics-CHIP-2011-09.pdf.

§§ 302(d)(1), 302(d)(4), 1701(a), 1703(d) (2009); The Henry J. Kaiser Family Foundation, Medicaid & Children's Health Insurance Program Provisions in Health Reform Bills 1 (Jan. 14, 2009) (Kaiser Reform Bills).[14] The Senate, by contrast, proposed to extend CHIP through 2019 and CHIP funding through 2015. Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 10203 (Dec. 24, 2009); Kaiser Reform Bills 1. The Senate bill also contained a provision mandating that CHIP-eligible children be enrolled on Exchanges operated by the states in the event of a funding shortfall, discussed in more detail below.

There was spirited debate within Congress about which of these two proposals to adopt, and the Senate version eventually prevailed. *See, e.g.*, Kaiser Health News, Health Reform Sparks Debate on Future of Children's Health Program (Nov. 18, 2009).[15] The salient point, however, is that both proposals took as a given that children currently receiving CHIP coverage should continue to receive health insurance, even if the program were later defunded. The House proposal completely eliminated the need for CHIP funding, substituting Medicaid and exchange coverage instead. The Senate proposal used the Exchanges as a backstop to cover any potential gaps created by funding shortfalls. But both sought to guarantee to future children the benefits

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[14] Available at https://www.aucd.org/docs/Medicaid%20and%20the%20Children%27s%20Health%20Insurance%20Program%20Provisions%20in%20Health%20%20Reform%20Bills.pdf.

[15] Available at http://kaiserhealthnews.org/news/childrens-health-insurance-program-chip/.

provided by CHIP—and neither suggested that any aspect of children's insurance coverage should turn on the mechanics of establishing a state insurance Exchange. In other words, Congress agreed that if future funding fell short (as it did in CHIP's early years) or if negotiations mirrored 2007 (when funding was twice vetoed), children and their families should not be abandoned without coverage.

C. Petitioners' Construction Of The Phrase "Exchange Established By A State" Contravenes Congressional Intent And Risks Depriving Millions Of Children Of Access To Healthcare

Congress ultimately extended CHIP through 2019, and funded it through September 2015. Kaiser Report at 1. The Act also provided a backstop for children in the event of a funding shortfall or cutoff (such as the one slated for late 2015). In a subparagraph titled "Assurance of exchange coverage for targeted low-income children unable to be provided health assistance as a result of funding shortfalls," Congress provided that in the event of a funding shortfall or nonrenewal, and after screening children on CHIP for Medicaid eligibility, a state must "establish procedures to ensure that [any remaining] children are enrolled in a qualified health plan that . is offered through an *Exchange established by the State* under section 18031 of this title." 42 U.S.C. § 1397ee(d)(3)(B) (emphasis added).[16] The ACA thus set up a sensible and simple solution for CHIP short-

[16] The same provision makes such children eligible for premium tax credits, allowing their families to afford Exchange coverage. 42 U.S.C. § 1397ee(d)(3)(B).

falls: Children left out of CHIP receive access to equivalent plans on the Exchanges.

Not under Petitioners' approach. Petitioners' core position is that the phrase "Exchange established by the State" in the ACA means only an Exchange established by a state *without any federal assistance*. Pet. Br. 3. But 34 states have declined to create Exchanges on their own. *Id.* at 7. On Petitioners' view, then, CHIP-eligible children in those 34 states would not be enrolled on the Exchanges if there were a shortfall in CHIP funding. In other words, according to Petitioners, Congress provided for children in 16 states to receive equivalent healthcare coverage if CHIP funding were insufficient—but also decided to deny children in the 34 other Federal Exchange states the same access to affordable healthcare.

That result makes little sense—so little that Petitioners do not even attempt to justify it in their brief.[17] The central goal of the backstop provision was to ensure that the children currently insured under CHIP would remain insured in the event that federal CHIP funding proved insufficient or nonexistent. If Petitioners were correct, the backstop Congress enacted would not be a backstop at all—it

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[17] The D.C. Circuit addressed this issue in its now-vacated opinion, in a cursory footnote devoid of citation. *See Halbig v. Burwell*, 758 F.3d 390, 406 n.10 (D.C. Cir. 2014). In the court's view, the statutory "oddity" regarding CHIP does not "make[] the statute nonsensical or otherwise meet[] the high threshold of absurdity." *Id.* But in the context of a statute enacted to increase access to care for all Americans, a construction that could *reduce* access to care for up to five million children is not an "oddity" or a mere quirk—it is a nonstarter.

would *eliminate* coverage in many states in the event of a funding shortfall, not *maintain* it.

There is no indication that Congress intended such an irrational result. Congress recognized that some states would elect not to establish their own Exchanges. *See, e.g.*, 156 Cong. Rec. H2207 (Mar. 22, 2010) (Rep. Burgess) (up to 37 states "may not set up the State-based exchange"); *see also Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2665 (2012) (*NFIB*) (joint dissent) ("Congress thought that some States might decline to participate in the operation of an exchange."). Yet nothing in the proceedings governing the CHIP reauthorization suggest that Congress intended to condition a child's eligibility for coverage in the event of a funding shortfall on the manner in which her state elected to establish an Exchange. To the contrary—the evidence demonstrates that Congress went to great lengths to guarantee coverage to all eligible children regardless of funding disputes. *See* 155 Cong. Rec. S11,457 (Nov. 18, 2009) (Sen. Casey) ("I believe the goal of this legislation, as it relates to those children, those who are poor or children with special needs, is four words: 'No child worse off.'"). Likewise, there is no sound basis for discriminating between states based on the type of Exchange they establish.

Congress of course could not predict in advance which states would opt to create their own Exchanges when it enacted the ACA. The division that currently exists, however, cannot justify the disparate treatment: To name just two examples, 12.2% of children in Federal Exchange states are born preterm, compared to 10.3% in states with their own Exchanges, and 8.4% of children in Federal Exchange states are born with a low birthweight, com-

pared to 7.3% in states with their own Exchanges.[18] Further, many of the states that accepted federal Exchange assistance have high poverty rates, which correlates with poor child health and the need for insurance coverage. *See* The Henry J. Kaiser Family Foundation, Distribution of the Total Population by Federal Poverty Level (above and below 100% FPL) (of the 25 states with the highest number of individuals under the federal poverty level, 18 have federally-facilitated Exchanges)[19]; Center for American Progress, The Economic Costs of Poverty in the United States: Subsequent Effects of Children Growing Up Poor 1 (Apr. 2007) (children who grow up in poverty are "more likely . . to have poor health later in life").[20]

Nor is the Exchange backstop provision irrelevant or minor, as the D.C. Circuit suggested. *Halbig v. Burwell*, 758 F.3d 390, 406 n.10 (D.C. Cir. 2014). As explained above, CHIP has repeatedly faced federal funding shortfalls. *See supra* at 9-11. And federal funding for CHIP expires on September 30, 2015. *See* Georgetown University Health Policy Institute, Center for Children & Families, About Chip 1.[21] Even though CHIP has enjoyed bipartisan sup-

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[18] These figures are based on the National Center for Health Statistics' 2012 Natality Data, available at http://www.marchofdimes.org/peristats, as analyzed by the March of Dimes Perinatal Data Center on January 14, 2015.

[19] Available at http://kff.org/other/state-indicator/population-up-to-139-fpl/.

[20] Available at http://www.irp.wisc.edu/publications/dps/pdfs/dp132707.pdf.

[21] Available at http://ccf.georgetown.edu/wp-content/uploads/2012/03/About-CHIP-20141.pdf.

port in the past, Congress has not yet passed a bill extending funding for the program. The consequences of non-renewal—which was on the table as recently as 2007—would be dire if Petitioners succeed in this case. If the government prevails, and CHIP funding is not renewed, children throughout the country could simply transition to the Exchanges operated in their states. But if Petitioners prevail, up to *five million* children currently on CHIP could lose access to affordable insurance coverage, simply because they happen to live in Federal Exchange states. *See* MACPAC Report at 68-69.[22] These children could not take advantage of tax credits to obtain CHIP-equivalent coverage on their state's Exchange because it was not exclusively established by the state. They would also be ineligible for Medicaid (because their families' incomes are too high) and unable to afford private coverage (because their families' incomes are too low).[23]

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[22] This figure consists of the sum of the numbers of children enrolled in CHIP in Federal Exchange states, based on the most recent available public information compiled by the Medicaid and CHIP Payment and Access Commission (MACPAC). MACPAC is a non-partisan federal agency charged with providing policy and data analysis and making recommendations to Congress on Medicaid and CHIP. *See* MACPAC Report at xix.

[23] It is true, but irrelevant, that a state could avoid the backstop provision by declining to participate in CHIP in the first place. The relevant point is that the backstop provision was designed to provide a uniform solution to funding shortfalls in every participating state—there is no indication that Congress wanted the backstop to operate differently because of a state's administrative decisions in establishing an Exchange.

It is important to note, however, that Petitioners' construction of the ACA would strip children of insurance even in the one state (Arizona) that has attempted to phase out CHIP. In

The Congress that extended CHIP, expanded the program to cover more children, and provided backstop Exchange coverage in the event of a funding shortfall, could not have intended these results. Congress "does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions—it does not, one might say, hide elephants in mouseholes." *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001). It did not do so here: Congress did not *strip* millions of children of backstop insurance coverage in the event of a funding shortfall simply by using the term "Exchange established by a State" in a statutory provision designed to "*[a]ssur[e]*" those children continuing coverage going forward. 42 U.S.C. § 1397ee(d)(3)(B) (emphasis added). The history of CHIP thus reveals that the phrase "Exchange established by the State" cannot have the meaning Petitioners suggest. A construction that "would be inconsistent with—in fact, would overthrow—the Act's structure and design," is unacceptable. *Utility Air Regulatory Grp. v. EPA*, 134 S. Ct. 2427, 2442 (2014).

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place of CHIP, Arizona enrolled some low-income children on Medicaid, and left the other 14,000 children to obtain tax-credit-eligible coverage on the state's Exchange. *See* Losing KidsCare at 1. But Arizona is a Federal Exchange state, meaning that the thousands of children transitioned to the Exchange would be without affordable insurance in the event Petitioners prevail.

II. ELIMINATING TAX CREDITS FOR INDIVIDUALS IN FEDERAL EXCHANGE STATES WOULD HAVE DEVASTATING CONSEQUENCES FOR INDIVIDUALS WITH PRE-EXISTING CONDITIONS

In addition to depriving countless children of their health insurance, Petitioners' construction of the term "Exchange established by the State" would upend the carefully-crafted insurance reforms at the heart of the ACA. Individuals with life-threatening conditions would lose the tax credits that allow many of them to obtain insurance and live with dignity, and would face the prospects of financial ruin or death. More broadly, insurance would become less affordable and less accessible for Americans in the private insurance market. These are precisely the results Congress sought to avoid—not (as Petitioners argue) results Congress intended to create.

A. Tax Credits For Low- And Moderate-Income Americans Are An Essential Part Of The ACA's Reforms To The Insurance Market

Congress enacted the ACA to provide more Americans access to health insurance, and so make healthcare affordable. *NFIB*, 132 S. Ct. at 2580. In particular, Congress sought to ensure that individuals with pre-existing health conditions would have access to insurance coverage. Federal law precluded employer-sponsored insurance plans from charging employees higher insurance premiums based on their health status or medical history. *See* Congressional Budget Office, Key Issues in Analyzing Major Health Insurance Proposals at xi (Dec. 2008) (Key

Issues).[24] But there was no similar restriction on insurance plans purchased in the individual market, so insurance companies routinely denied coverage or charged high premiums even to individuals with common conditions like asthma and pregnancy. 47 Million and Counting: Why the Health Care Marketplace Is Broken: Hearing Before the Senate Comm. on Finance, 110th Cong., 2d Sess. 52 (2008) (statement of Professor Mark A. Hall). Around 80% of the 45 million Americans without employer-sponsored or government insurance—some of whom had severe, life-threatening conditions—were uninsured. Key Issues at 46; U.S. Gov't Accountability Office, Private Health Insurance: Estimates of Individuals with Pre-Existing Conditions Range from 36 Million to 122 Million 12 (Mar. 2012) (Pre-Existing Conditions) (depending on the practices of particular insurers, 20% to 66% of the adult population has a pre-existing condition).[25]

In direct response to that state of affairs, Congress enacted two provisions, known as "guaranteed issue" and "community rating." Together, those provisions "prohibit insurance companies from denying coverage to those with [pre-existing conditions] or charging unhealthy individuals higher premiums than healthy individuals." *NFIB*, 132 S. Ct. at 2585 (opinion of Roberts, C.J., citing 42 U.S.C. §§ 300gg, 300gg-1, 300gg-3, 300gg-4). Insurance companies thus would have to "accept unhealthy individuals [without] charging them rates necessary to pay their coverage." *Id.*

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[24] Available at http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9924/12-18-keyissues.pdf.

[25] Available at http://www.gao.gov/assets/590/589618.pdf.

Congress knew, however, that these requirements were not economically feasible standing alone. "When insurance companies are required to insure the sick at affordable prices, individuals can wait until they become ill to buy insurance." *NFIB*, 132 S. Ct. at 2614 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part); *see* Health Reform in the 21st Century: Insurance Market Reforms: Hearings before the House Ways and Means Comm., 111th Cong., 1st Sess., 10, 13 (2009) (statement of Professor Uwe E. Reinhardt) ("[I]mposition of community-rated premiums and guaranteed issue on a market of competing private health insurers will inexorably drive that market into extinction.").

Accordingly, Congress enacted two equally important reforms designed to pay for the nondiscrimination provisions. First, the ACA requires most individuals to purchase health insurance or pay a tax penalty (the "individual mandate"). See 26 U.S.C. § 5000A. Second, to encourage individuals to enter the insurance market (rather than merely pay the tax penalty), Congress provided that individuals who met certain income criteria would qualify for tax credits to enable them to purchase insurance on the Exchanges at low cost. *See* ACA § 1401, codified at 26 U.S.C. § 36B.

The tax credits are an absolutely essential component of the ACA's insurance reforms. *See, e.g.*, H.R. Rep. No. 111-443, 111th Cong., 2d Sess., vol. I, at 250 (2009) (noting that tax "credits are key to ensuring people affordable health coverage"). Congress was fully aware that it was essential to expand insurers' risk pools to include younger, healthier individuals to counterbalance the certain

influx of seriously ill people. *NFIB*, 132 S. Ct. at 2614 (Ginsburg, J., concurring in part, concurring in the judgment in part and dissenting in part). At the same time, Congress recognized that it would be futile to require those individuals to purchase insurance they could not afford. S. Rep. No. 111-89, 111th Cong., 1st. Sess. 4 (2009) (Congress sought "[t]o ensure that health coverage is affordable"). The tax credits bridge that divide. At the time of the ACA's enactment, the CBO estimated that tax credits would be available to 78% of individuals purchasing insurance on the Exchanges. Congressional Budget Office, An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act 24 (Nov. 30, 2009).[26] And recent studies have shown that the tax credits have a still broader reach: Almost *90%* of people purchasing insurance on the Exchanges have relied on tax credits. *See* Amy Burke et al., ASPE Research Brief: Premium Affordability, Competition, and Choice in the Health Insurance Marketplace 3 (June 18, 2014) (ASPE Research Br.).[27]

Petitioners' approach to the ACA would make most Americans ineligible for the tax credits, and sabotage the ACA's insurance reforms. As explained above, Petitioners' view is that tax credits are available only to individuals living in the minority of states that have established their own Exchanges without any federal involvement. Pet. Br. 11. If Petitioners are correct, many individuals with pre-

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[26] Available at http://www.cbo.gov/sites/default/files/11-30-premiums.pdf.

[27] Available at http://aspe.hhs.gov/health/reports/2014/premiums/2014mktplaceprembrf.pdf.

existing health conditions (and countless other, healthier Americans) would be ineligible for tax credits, simply because they happen to live in Federal Exchange states. That result would strip millions of Americans of insurance coverage, as described in the section that follows.

B. The ACA's Successful Insurance Reforms Would Collapse If Petitioners Prevail

The ACA has extended affordable health coverage to millions of Americans, providing them security and peace of mind regarding their health. In the ACA's first year, more than 10 million previously-uninsured adults secured insurance, causing the uninsured rate to plummet by approximately 5.3 percentage points. *See, e.g.*, Sharon K. Long et al., Taking Stock: Health Insurance Coverage under the ACA as of September 2014, at 1 (Dec. 3, 2014)[28]; Benjamin D. Sommers et al., *Health Reform and Changes in Health Insurance Coverage in 2014*, 371 New Eng. J. Med. 867, 871 (2014). Over 8 million people obtained that insurance through the Exchanges. *See* Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period (Initial Annual Open Enrollment), Department of Health and Human Services 12, 37 (May 1, 2014).[29] Sixty percent of them were previously uninsured. Liz Hamel et al., Survey of Non-Group Health Insurance Enrollees, Kaiser Fam-

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[28] Available at http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of-September-2014.pdf.

[29] Available at http://aspe.hhs.gov/health/reports/2014/marketplaceenrollment/apr2014/ib_2014apr_enrollment.pdf.

ily Foundation (Jun. 19, 2014).[30] Like the individual amici, many of those individuals have pre-existing health conditions that, prior to the ACA's enactment, could have resulted in high premiums or coverage restrictions. Pre-Existing Conditions at 12.

The majority of individuals purchasing Exchange insurance did so on federally-facilitated Exchanges. Indeed, by January 16, 2015—with a month remaining in the ACA's second open enrollment period—7.1 million Americans had purchased insurance on federally-facilitated Exchanges. *See* Department of Health and Human Services, Open Enrollment Week 9: January 10, 2015 January 16, 2015 (Jan. 21, 2015).[31] Critically, nearly all of those individuals purchased plans at least partially offset by tax credits, resulting in net premiums that were, on average, 76% lower than the full amount. ASPE Research Br. at 3. Those tax credits allowed many individuals to receive coverage and thus care they would not have been able to access or afford prior to the ACA. Sara R. Collins et al., Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period, Commonwealth Fund 11-12 (July 2014).[32]

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[30] Available at http://kff.org/health-reform/report/survey-of-non-group-health-insurance-enrollees/.

[31] Available at http://www.hhs.gov/healthcare/facts/blog/2015/01/open-enrollment-week-nine.html.

[32] Available at http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/jul/1760_collins_gaining_ground_tracking_survey.pdf (75% of previously-uninsured individuals nationwide obtained access to affordable care).

A ruling for Petitioners would reverse these gains, because tax credits would no longer be available in Federal Exchange states. Individuals with pre-existing health conditions like amici would no longer be able to obtain affordable healthcare coverage, returning them to lives full of financial instability and insecurity. Millions of healthy individuals would decline to enroll in the individual market—a recent study by Rand Corporation projected that 8 million people would forgo insurance altogether in Federal Exchange states. Evan Saltzman & Christine Eibner, The Effect of Eliminating the Affordable Care Act's Tax Credits in Federally Facilitated Marketplaces 2 & n.4 (Jan. 2015) (Rand Study).[33] People would purchase costly insurance only when they became sick—no sooner—and projections show that the absence of offsetting revenue from healthy individuals would cause premiums to rise by almost 50%. *Id.* at 2.

The effects of a ruling in Petitioners' favor would not merely be limited to individuals who already receive tax credits. As healthy individuals leave the insurance market and sick people remain, premiums would rise for all purchasers, including individuals who currently purchase insurance without tax credits. Linda J. Blumberg et al., Characteristics of

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[33] Available at http://www.rand.org/content/dam/rand/pubs/research_reports/RR900/RR980/RAND_RR980.pdf. In particular, the RAND Study found that "[e]nrollment in the ACA-compliant individual market, including plans sold in the marketplaces and those sold outside of the marketplaces that comply with ACA regulations, would decline by 9.6 million, or 70 percent," in Federal Exchange states. Rand Study at 2. Of those 9.6 million people, "8.0 million become uninsured. The remaining 1.6 million find coverage through another source." *Id.* at n.4.

Those Affected by a Supreme Court Finding for the Plaintiff in King v. Burwell 7 (Jan. 2015) (Characteristics) ("Those not receiving tax credits under the current implementation of the law would be affected by a finding for King, as well, as the premiums for everyone would increase due to the worsening health status of those involved.")[34]; Linda J. Blumberg et al., The Implications of a Supreme Court Finding for the Plaintiff in King vs. Burwell 1, 6 (Jan. 2015) (Implications) ("Without federal tax credits, the population purchasing nongroup coverage would be in worse health, on average. As a result, premiums for nongroup coverage would be notably higher in FFM states than they would be with the credits in place.").[35] Some of those individuals, in turn, would leave the market, because of the premium spikes. *See* Characteristics at 3; Implications at 7. The market would be dominated by the precise adverse selection "death spiral" that the tax credits were designed to avoid. *See NFIB*, 132 S. Ct. at 2614 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part).

Petitioners' reading of the phrase "Exchange established by the State" would thus unravel the core reforms of the ACA—reason enough to reject their view. Congress would not have set out to make insurance accessible and affordable and then have undermined that plan by including a trapdoor statutory phrase in a small handful of provisions. Basic prin-

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[34] Available at http://www.urban.org/UploadedPDF/2000078-Characteristics-of-Those-Affected-by-King-v-Burwell.pdf.

[35] Available at http://www.urban.org/UploadedPDF/2000062-The-Implications-Kingvs-Burwell.pdf.

ciples of statutory interpretation—and common sense—compel rejection of Petitioners' arguments.

III. CHIP AND THE ACA'S INSURANCE REFORMS HAVE ALLOWED CHILDREN AND INDIVIDUALS WITH PRE-EXISTING HEALTH CONDITIONS TO LIVE WITH DIGNITY

CHIP and the ACA have allowed many Americans to obtain a degree of personal and financial liberty and security that was previously impossible. The stories that follow provide discrete, real-world examples of those benefits, and underscore how Petitioners' arguments stand squarely at odds with Congress's design.

A. CHIP Has Provided Essential Healthcare Coverage To Vulnerable Children

1. Congress has repeatedly heard testimony regarding the ways in which CHIP has improved the health of children across the country.

In 2007, for example, the Senate heard the story of a single mother named Kitty Deames Burgett. *See* 153 Cong. Rec. S10,537, 10,555-56 (Aug. 1, 2007) (statement of Sen. Stabenow). Burgett's husband died before CHIP came into existence, and the money from her Social Security survivor's benefits put her and her two young children over the Medicaid eligibility levels. *Id.* at S10,555. Burgett was able to purchase insurance for her children on the private market, but eventually had to forgo it because the premiums grew more expensive each year. *Id.* Things changed once Ohio agreed to participate in CHIP—Burgett was able to obtain insurance coverage for her two children. *Id.* That insurance allowed

her daughter to obtain comprehensive treatment for serious, often-debilitating psychiatric problems. *Id.* at S10,555-56. Today, Burgett's daughter is a productive, contributing member of society and a loving mother. *Id.* at S10,556.

Congress also heard about Graeme Frost, a 12 year old who might have died if not for CHIP *See, e.g.*, 153 Cong. Rec. S12,835, 12,840 (Oct. 15, 2007); 153 Cong. Rec. H11,471, 11,472 (Oct. 10, 2007). Graeme's mother, brother, and sisters were involved in a car crash in 2004 that caused serious injuries to the entire family. 153 Cong. Rec. at S12,840. Graeme had a brain injury and was in a coma for weeks. *Id.* One of his vocal cords was paralyzed, and one of his eyes was permanently damaged. *Id.* CHIP provided coverage for all of Graeme's treatments, which his family might otherwise have been unable to afford. *Id.*; *see also* 153 Cong. Rec. S10,401, 10,404 (July 31, 2007) (Sen. Brown) (Ohio's CHIP has allowed a family to obtain insurance coverage for their son's Down Syndrome).

2. Since Congress reauthorized CHIP in 2007, countless other parents have shared CHIP success stories with the public in an effort to ensure that the program remains in effect. CHIP has allowed children in California to obtain treatment for precancerous growths, hearing loss, broken bones, and diabetes. *See* Portraits of Healthy Families: Why All California Children Need Health Insurance: Success Stories For Parents, Kids, and the State.[36] It has permitted children in Colorado to receive treatment for growth hormone deficiencies and debilitating

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[36] Available at http://ccf.georgetown.edu/wp-content/uploads/2012/03/california-story-pamphlet.pdf.

neurological conditions. *See* All Kids Covered, CHIP Stories.[37] And it has ensured that children in Utah can receive treatment for leukemia and injuries sustained in a car accident. Utah Department of Health, CHIP Success Stories.[38]

B. The ACA Has Allowed The Individual Amici To Obtain Affordable Insurance And Lifesaving Treatments For Their Pre-Existing Medical Conditions

1. Aidan Robinson has a condition called Marfan Syndrome, which is a genetic disorder affecting the body's connective tissue. Individuals with the disorder have a defect in the gene that tells the body how to make a key protein in connective tissue, putting them at risk for glaucoma, collapsed lungs, and heart and blood vessel problems that can culminate in death.[39]

Aidan's parents, Eric and Martha, had insurance for most of his life through Martha's job as a school psychiatrist. When Martha left that job to found a small charter school and start her own business, she purchased COBRA continuation health insurance coverage for a year and a half. Once that insurance expired, however, Martha could not obtain private coverage for her family—time after time, insurers turned her down because of Aidan's condition. Aidan was unable to obtain necessary medication

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[37] Available at http://www.allkidscoveredcolorado.org/issues-initiatives/chip-works/chip-stories/.

[38] Available at http://health.utah.gov/chip/sucessstories.htm.

[39] The Marfan Foundation, What Is Marfan Syndrome? http://www.marfan.org/about/marfan.

and screening, meaning he was deprived of the most basic liberties. He could not travel (or leave the house), work, or engage in even moderate physical activity.

Things changed once the ACA was enacted. Aidan's family was immediately able to purchase insurance coverage through Indiana's Exchange and obtain tax credits to offset the premiums. So long as the tax credits are available, Aidan can live a normal life, free of the fear that his medical condition will bankrupt his family.

2. David Tedrow and his wife, Mary, owned a successful business in South Carolina until David was diagnosed with end-stage liver failure disease. David desperately needed a liver transplant, and moved to North Carolina to be closer to a surgeon at Duke University who specialized in treating patients like David. Upon moving to North Carolina, David purchased temporary insurance and was placed on the liver transplant waiting list. Shortly thereafter, David's insurer folded, placing David in a precarious position: He needed insurance to remain on the transplant list, but every private insurer denied him coverage because of his pre-existing condition.

The ACA solved that problem. David was able to obtain insurance, offset by tax credits, on North Carolina's federally-assisted Exchange—insurance that paid the costs of his liver transplant. Unfortunately, the transplant did not bring David to full health—during the transplant surgery, doctors found a tumor on David's liver, and diagnosed him with cancer. But David's coverage under the ACA has allowed him to obtain the necessary treatment for his cancer. Without the ACA, David would be

facing a life-threatening disease without any insurance and any realistic hope of paying for therapy.

3. Steve Orofino was diagnosed with prostate cancer in 2010. At the time, he had employer-provided insurance through his job as a chemist, and was able to obtain surgery and follow-up treatments at minimal cost.

One year later, Steve's cancer returned, just as he was downsized at work. Like the Robinsons, Steve purchased COBRA extension coverage, but he was unable to obtain private insurance coverage once the COBRA coverage expired—both because of his cancer and his wife's diabetes. Steve purchased coverage from North Carolina's high-risk pool, but the costs of treatment almost bankrupted his family.

The ACA's insurance coverage and tax credits have turned things around for Steve and his wife. They now receive affordable and effective treatment for their conditions, and no longer have to face a choice between liquidating their life savings and their health.

4. Jared Blitz was born with aortic valve stenosis (a narrowed aortic valve opening). As a child, the costs of his treatment—including a $200,000 open-heart surgery—were covered by his parents' health insurance. But after obtaining his college degree, Jared's insurance expired. The only plan he could find on the private market contained an exception for his heart condition. A few years later, Jared looked for a new plan, but the best available option covered only 60% of his heart condition with no out-of-pocket maximum. Once Arizona's Exchange opened, however, Jared obtained a plan that will al-

low him to obtain treatment and potential future procedures without incurring financial ruin.

* * *

The stories just described illustrate the ways in which CHIP and premium tax credits allow children and adults to experience the liberty and dignity that accompany good health. Congress would not have conditioned the well-being of some of the most vulnerable members of society on their home states' decisions to obtain federal assistance in establishing an Exchange. The ACA was meant to help amici and the people they represent; it should not be construed in a manner that would affirmatively harm them.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be affirmed.

Respectfully submitted.

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January 28, 2015

APPENDIX

APPENDIX: LIST AND DESCRIPTION OF *AMICI CURIAE*

The **American Academy of Pediatrics** (AAP) is an organization of 62,000 primary care pediatricians, pediatric sub-specialists, and pediatric surgical specialists dedicated to the health and well-being of all infants, children, adolescents, and young adults. AAP seeks to ensure that all children have access to continuous and comprehensive care.

The **American Academy of Family Physicians** (AAFP), headquartered in Leawood, Kansas, is the national medical specialty society representing family physicians. Founded in 1947 as a not-for-profit corporation, its 115,900 members are physicians and medical students from all 50 states, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and the Uniformed Services of the United States. The AAFP seeks to improve the health of patients, families, and communities by advocating for the health of the public and serving the needs of members with professionalism and creativity.

Children's Health Fund (CHF) was founded in 1987 with the goal of providing healthcare to children in rural and urban communities throughout the country. CHF has provided care to over 200,000 children, and has sponsored public education and advocacy campaigns designed to promote access to healthcare for low-income children.

The **Children's Hospital Association** represents more than 220 children's hospitals nationally and advances child health through innovations in the quality, cost, and delivery of care. On average, more than 52 percent of children served by children's

hospitals rely on Medicaid or CHIP for their healthcare coverage.

First Focus is a bipartisan advocacy organization that is committed to making children and families a priority in federal policy and budget decisions. In all of its work, First Focus strives to ensure that every child in America has access to the high quality, comprehensive, affordable healthcare they need to grow up to become healthy and productive adults.

March of Dimes (MOD) is a nonprofit organization that advocates for mothers and children. MOD was founded by President Franklin Delano Roosevelt in 1938 to combat polio, and has expanded its mission to improve the health of babies by preventing birth defects, premature birth, and infant mortality.

The **National Physicians Alliance** (NPA) is a non-partisan, non-profit organization that creates research and education programs that promote health and foster active engagement of physicians with their communities to achieve high quality, affordable healthcare for all. NPA represents physicians across medical specialties who share a commitment to professional integrity and health justice.

Jared Blitz, Steve Orofino, Aidan Robinson, Martha Robinson, David Tedrow, and Mary Tedrow are individuals or family members of individuals who suffer from life-threatening health conditions. Prior to the ACA's enactment, they were unable to maintain adequate insurance coverage on the individual market on account of those conditions. Today, they receive tax credits that allow them to purchase insurance on federally-facilitated Exchanges—insurance that has allowed them to obtain life-

saving treatments. They would lose those tax credits, and thus their insurance coverage, if Petitioners prevail in this case.